Attachment H

Notification of Amendment to Protected Health Information

To: __________________________
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From: HIPAA Privacy Officer for (insert dept.)
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Date: __________________________

Your request to amend your protected health information submitted to CMU on ________________ has been approved. The following amendment has been made to your records:
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In order that we may correct all of your records, we will need a list of the individuals and/or organizations that you would like us to notify about the change in your record. Use the space below (add additional pages if necessary) to identify the contacts you would like us to make about the change. Please sign and return the authorization below.

I authorize CMU to distribute the amendment requested by me to individuals and organizations listed below.

____ ____________
Client/Patient/Employee Signature Date

____
Guardian Signature, if appropriate

____
Relationship to Client

Amendment Distribution List:

Name: __________________________
Address: __________________________
____
Phone: __________________________

Name: __________________________
Address: __________________________
____
Phone: __________________________

(Please use additional pages if necessary.)

Revised as of 4/10/03